Ohio Association of
County Behavioral Health Authorities

Joint Medicaid Oversight Committee
Comments provided by: Cheri L. Walter
May 26, 2016

Chairman Burke, Vice Chair Sears, and members of the Joint Medicaid Oversight Committee, thank you for inviting me to join this panel. My name is Cheri L. Walter and I am the CEO of the Ohio Association of County Behavioral Health Authorities. We represent Ohio's Alcohol, Drug Addiction, and Mental Health Boards.

At the local level, the ADAMH Boards are focusing on transitioning their local systems to become Recovery-Oriented Systems of Care. A Recovery-Oriented System of Care places its primary focus on individuals in need of recovery services and their families, building on their strengths, and incorporating a coordinated and collaborative approach across the community. The foundation of Ohio's Recovery-Oriented Systems of Care is locally managed continuums of care with all of the partners working together toward a system designed to provide person-centered prevention, treatment, and support services to help individuals and families impacted by mental illness and addiction achieve and sustain long-term recovery. This work puts clients and families at the forefront of policy, system, and individual decisions.

As we talk about the continuum of care for addiction services in Ohio, I have to again express our appreciation for Medicaid expansion in Ohio. Individuals with an addiction throughout Ohio have better access to treatment and recovery services through the Medicaid program because they are now eligible based on their income. Medicaid expansion has been a tremendous benefit for the addiction treatment community. As I say that, I want to also dispel some myths about the impact of expansion. Medicaid expansion has opened up access to treatment services and it has allowed local boards to free up some resources to utilize for recovery supports, but Medicaid expansion alone will not meet all of the needs of individuals with an addiction. Medicaid will cover core treatment services that are desperately needed as individuals enter recovery. Medicaid will not cover all of the recovery supports necessary to sustain recovery in the community. For example, Medicaid will cover the treatment components of a residential treatment program, but it will not cover the room and board expenses related to staying in a residential program. Comparably, Medicaid will cover a crisis service, but only at the time the service is delivered. Medicaid won't cover the costs related to keeping the lights on and the doors open to ensure that there is access to crisis services when they are needed. Additionally, Medicaid doesn't cover things like recovery housing, employment services, and some transportation services needed by individuals as they continue down their recovery path. This is where the local Boards come in with their local Recovery-Oriented System of Care to meet the varied and complex needs of clients and families.

As Kay will explain when she talks about her local system, Boards are on the ground in the community planning, evaluating, and funding the local services, while all the time working with their local partners to provide a complete and accessible continuum of care for mental health and addiction services.

As the community behavioral health Medicaid benefit is redesigned in Ohio, we are working closely with OhioMHAS, the Ohio Department of Medicaid, and the Managed Care Organizations to do our part to ensure a smooth transition for recipients of services throughout the state. Recently, we partnered with the state agencies leading this work to host seven regional behavioral health redesign 101 trainings and we're planning to host an additional eight trainings in the fall as the redesign work continues. Our goal is to help community organizations and individuals clearly understand the coming changes and have an opportunity to provide feedback from the field. We recognize that the changes are coming fast upon us and that the magnitude of change is large. We are supportive of the redesign efforts, but we want to ensure that the appropriate protections are in place so as not to disrupt services to clients in need. We are recommending the development of a short-term problem solving workgroup to identify and swiftly address any challenges that arise during the transition to new codes and rates, and as we implement the new Specialized Recovery Support Program, and then again during the transition to managed care. We need to have a structure in place to rapidly respond to issues that will impact service to clients. We are also recommending the development of a plan for evaluating the long-term impact of the changes on access to services; client outcomes; and remaining gaps in services.

As we discuss the continuum of care in local systems, we must also discuss the new statutory requirements that are coming for local Boards. The language, which will now be effective on July 1, 2017 thanks to an amendment that was passed yesterday, will require local Boards to have a full, extensive continuum of care for individuals with opiate and co-occurring substance use disorders. This continuum outlines all of the levels of care and references the geographic bounds (the Board service district) where most of these services must be accessible. If a Board can't meet the requirements of the continuum of care, the state must withhold their state and federal funding. We understand and appreciate the incentive to have a robust system of care in all communities, but the reality is that in some communities the economies of scale just simply don't exist to staff, operate, and fund all of these services. We continue to work with the state and the general assembly to discuss the impact of this requirement and develop solutions that best meet the needs of individuals working to achieve recovery in communities throughout Ohio.

I'll give you some specific examples of our concerns. As we surveyed the local Boards, we found that 27 won't meet the continuum of care as defined today. The majority of these won't meet the requirements of the statute because they don't have ambulatory detoxification services within the geographic bounds of their service district. There are many reasons that the Boards don't have the service within their Board area: some have a contract with a facility in a neighboring Board area; some aren't able to find a physician who is willing to provide the medical supervision for an ambulatory detoxification program that utilizes a medication-assisted treatment model; some have what we'd refer to as ambulatory-detox "light" where they are able to offer services that look like ambulatory detox, but don't meet the certification criteria to be officially called ambulatory detox; and some have tried to bid out for the service and have received responses with some astronomical price tags (as much as double or triple the Medicaid rate for the

service). We're not saying the local communities shouldn't have access to ambulatory detox, we believe that is a very important part of the continuum. What we are saying is that we believe we need to have some additional discussions about the barriers that are currently impacting the ability to deliver ambulatory detox so that we can come to some consensus about developing solutions that don't put at risk other treatment and recovery services for individuals with addictions and/or mental illness because local Boards are forced to shift funds to meet statutory priorities that may not align with the priorities of their local communities.

We know the opiate epidemic is a crisis, but we can't divert all of our energy and resources to address this crisis, without running the risk of missing or starting another crisis. For instance, some of our communities are seeing as many suicides as overdoses. In some communities, the rate of suicide is actually higher than the rate of overdose. This is why local Boards with local providers in local systems of care bring strength to Ohio's community behavioral health system. They are able to rapidly respond to changing concerns in the community.

These are the kind of unique, local scenarios that our Boards work with on a daily basis in Ohio's very varied communities. Meeting the needs of the individuals in Brown County takes a different approach than in Cuyahoga County. Ohio's community Board structure allows for planning, evaluating, and funding services at the local level in order to best meet local needs. We need to continue to allow flexibility for local systems as they work to creatively and innovatively meet the unique needs of their board area.

We look forward to continuing to work with the members of the General Assembly and the state administration in order to continue to reform and refine Ohio's community behavioral health system so that we can all partner together to ensure that individuals are able to access the services and support that they need in healthy, safe, and drug-free communities. I truly believe that Recovery Is Beautiful, and I look forward to working with all of you to make recovery a reality for all Ohioans.